American Hospital Association™
Advancing Health in America

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November 20, 2026

Noah Aleshire
Chief Regulatory Officer
Centers for Disease Control and Prevention
1600 Clifton Road, NE
MS H21-8
Atlanta, GA 30329

Submitted Electronically

RE: CDC-2026-1519 Data Intermediaries and Approaches to Strengthen Public Health Data Exchange

Dear Mr. Aleshire,

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comment on the Centers for Disease Control and Prevention (CDC) request for information (RFI) regarding data intermediaries and opportunities to strengthen public health data exchange.

Our members recognize the importance of timely, accurate and actionable data to support public health activities. The ability for patients, providers, public health agencies and communities to transmit and exchange data can support broader population health objectives of preventing disease, detecting threats and responding effectively to public health events. As frontline providers, hospitals and health systems play a critical role in public health reporting processes. As technology advances, we appreciate that the CDC continues to evaluate ways to improve public health data exchange to advance safety and support a healthier nation, and specifically, how intermediaries can support scalable exchange.

The AHA supports public health data exchange modernization and well-designed data intermediaries' integration, provided they reduce fragmentation, build on existing infrastructure and do not add new burdens or costs for hospitals. To that end, the AHA recommends that the CDC:

- Ensures that data intermediaries reduce inappropriate variability rather than adding another layer of complexity.
- Supports and complements existing data exchange capabilities like Trusted Exchange Framework and Common Agreement (TEFCA), Health Information Exchanges (HIEs), and Qualified Health Information Networks (QHINs).
- Aligns incentives and supporting infrastructure investment, particularly for rural and critical access hospitals.
- Prioritizes privacy and security of patient data as the agency explores opportunities for public health data exchange modernization.
- Synchronizes its efforts with the Office of the National Coordinator (ONC) and Centers for Medicare & Medicaid Services (CMS) to ensure alignment of standards and timelines.
- Leverages lessons learned from electronic case reporting (eCR).

Our detailed comments are below.

ENSURE DATA INTERMEDIARIES REDUCE VARIABILITY

Hospitals and health systems see the potential value in public health data intermediaries, which can streamline and reduce the number of point-to-point connections. For the purposes of the RFI, the CDC defined public health data intermediaries as "trusted organizations, networks, platforms, or governed services that enable secure, standards-based exchange and stewardship of health-related data among data sources and public health authorities by providing shared technical, operational, and governance capabilities that seek to reduce connectivity burden and improve the quality, timeliness, and usefulness of data for public health practice, while protecting individual privacy and confidentiality."

Intermediaries have the potential to streamline connections to support reporting needs. Variability in reporting requirements has resulted in fragmented data exchange, often adding connections, multiple contracts and increased costs, including interface development, testing, troubleshooting, updates and support. In 2024, 55% of hospitals reported that the technical complexity of interfaces, transmission or submission processes is a challenge to public health reporting.[1] As the CDC evaluates opportunities to modernize public health data exchange and advance data intermediaries, we encourage the agency to ensure these entities reduce variability rather than add yet another layer of complexity. As such, the CDC could evaluate data intermediaries on criteria such as whether they reduce the number of endpoints, connections and interfaces.

[1] https://www.ncbi.nlm.nih.gov/books/NBK616186/?report=printable

SUPPORT EXISTING CAPABILITIES

Public health data exchange has progressed significantly in the past several years through expanded capabilities such as the TEFCA, HIEs, QHINs and other health data utilities. Participation and utilization of these capabilities have increased significantly over the last few years. For example, since December 2023, almost 500 million records have been exchanged in TEFCA across 71,000 participants, with approximately 490 million records exchanged in 2025.[2] For public health exchange in particular, progress is shown by the establishment of distinct public health exchange types for frameworks like TEFCA and increased rates of optional reporting types.[3] As public health exchange use increases, we urge the agency to pursue efforts that complement existing infrastructure rather than create separate frameworks.

In other words, the introduction of intermediaries should be synchronized within existing frameworks and aligned with existing capabilities, as opposed to introducing intermediaries in new frameworks. This will support broader interoperability objectives and minimize costs for entities that have already invested in technical and operational workflows with these capabilities. Establishing new frameworks outside these existing capabilities would lead to redundancies and inefficiencies.

ALIGN INCENTIVES AND SUPPORT INFRASTRUCTURE INVESTMENT

Modernizing public health data exchange has significant benefits. At the same time, implementation entails significant costs that could hinder hospitals and health systems' ability — especially those serving rural and underserved communities — to participate in reporting. Small, rural, independent and critical access hospitals have engaged in fewer types of electronic public health reporting on average compared to other hospitals.[4] This is in part due to staffing, data infrastructure and technical capability costs. We encourage the CDC to support investment for entities like rural hospitals and critical access hospitals that may lack resources to support public health data exchange. This could be through shared infrastructure investment, technical resources, grant funding or other financial support. We also urge the agency to develop centralized onboarding assistance through regional extension centers. This will support adoption across hospital types and geographies.

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[2] https://www.hhs.gov/press-room/tefca-americas-national-interoperability-network-reaches-nearly-500-million-health-records-exchanged.html

[3] Ibid. In 2024, 94-97% of hospitals engaged in electronic public health reporting for core data types; over 62% engaged in electronic public health data exchange for optional data types. Both have increased over time.

[4] Ibid. In 2024, rural hospitals engaged in an average of 6.1 reporting types compared to 6.4 for non-rural. Critical access hospitals engaged in an average of 6.0 reporting types compared to 6.4 for non-critical access. Both comparisons were statistically significant.

PRIORITIZE PRIVACY AND SECURITY OF DATA

Patients entrust hospitals and health systems with guarding their protected health information (PHI). That is why privacy and security considerations are paramount for hospitals when considering new approaches to exchanging health data, including for public health purposes. As covered entities under HIPAA, hospitals and health systems also have legal obligations to ensure patient data protection. Federal privacy regulations generally require covered entities such as hospitals to take reasonable steps to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose. The Department of Health and Human Services' frequently asked questions reiterate that for public health purposes, "For disclosures that are not required by law, covered entities may disclose, without authorization, the information that is reasonably limited to that which is minimally necessary to accomplish the intended purpose of the disclosure."[5]

As the CDC explores opportunities to advance public health data exchange, we urge the agency to ensure that intermediaries and any other entities handling PHI as part of public health data exchange are held to the same HIPAA privacy and security standards as covered entities (including minimum necessary standards). This will foster trust in exchange when all parties are subject to the same standards and accountability. Without such provisions, hospitals, health systems and other covered entities will continue to bear disproportionate risk for factors outside of their control.

SYNCHRONIZE EFFORTS WITH OTHER AGENCIES

We appreciate the critical role the CDC plays in aligning public health data streams, removing barriers to exchange, and improving data availability to inform public health response and improve population health. Other federal agencies also support different public health exchange aspects. Therefore, we urge the CDC to coordinate and synchronize efforts with those agencies. For example, we recommend that the CDC work with ONC to ensure health IT standards and certification criteria are aligned with reporting needs. Similarly, we encourage the CDC to work with CMS to ensure alignment with Promoting Interoperability program components.

LEVERAGE LESSONS LEARNED FROM HISTORIC EFFORTS

Before proposing updates to public health exchange frameworks to account for intermediaries, we encourage the agency to review lessons learned from eCR, which automates the exchange of case reports between electronic health records and public health agencies, and the development of the Association of Public Health Laboratories Informatics Messaging Services platform. eCR provides a mechanism for healthcare

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[5] https://www.hhs.gov/hipaa/for-professionals/faq/296/may-covered-entities-disclose-facially-identifiable-protected-health-information/index.html

organizations to transmit case reports through a centrally managed resource to route to the appropriate jurisdiction. This minimizes requirements for hospitals to build, test and troubleshoot separate connections with each jurisdiction. The eCR use case provides valuable lessons learned on shared infrastructure, centralized connections and concentrated onboarding resources.

Our members strongly support efforts to modernize public health exchange and pursue intermediary-based models to reduce variability, and we encourage the agency to synchronize with existing infrastructure, align incentives to support exchange and prioritize privacy and security as foundational to any efforts.

We thank the CDC for the opportunity to comment, and look forward to working with the agency to modernize public health data exchange. Please contact me if you have questions, or feel free to have a member of your team contact Jennifer Holloman, AHA director of health IT policy, at jholloman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development